Fatigue Questionnaire

Patient ID __ __ - __ **ID** __ - __ __ __

Date of Evaluation: **DOEDATE**

Protocol timepoint *(see codes)*: **TMPT**

Instructions: This questionnaire captures symptoms of fatigue and the experience and impact fatigue has on daily activities. For each statement or question, mark one box.

Form completed by *(check all that apply)*:
☐ Patient **COMP** ☐ Coordinator **COMC** ☐ Interpreter **COMI**
☐ Family member/friend **COMF** ☐ Other **COMO**

In the past 7 days…

	Never	Rarely	Sometimes	Often	Always
1. How often did you feel tired? **FQTIRED**	☐	☐	☐	☐	☐
2. How often did you experience extreme exhaustion? **FQEXHAU**	☐	☐	☐	☐	☐
3. How often did you run out of energy? **FQENGY**	☐	☐	☐	☐	☐
4. How often did your fatigue limit you at work (include work at home)? **FQWORK**	☐	☐	☐	☐	☐
5. How often were you too tired to think clearly? **FQTHINK**	☐	☐	☐	☐	☐
6. How often were you too tired to take a bath or shower? **FQBATH**	☐	☐	☐	☐	☐
7. How often did you have enough energy to exercise strenuously? **FQEXER**	☐	☐	☐	☐	☐

Thank you for completing this questionnaire!